## **Designation of Health Care Surrogate**

Name:				_	
				formed consent for medical my surrogate for health care	
Name					
	ess				
City		State	Phone		
Phone:					
If my surrogate is u surrogate:	nwilling or unable	to perform his or	her duties, I wish	to designate as my alternate	
Name					
Street Addı	ess				
City	ess	State	Phone		
health care; and to a Additional instructi	ons (optional):			e facility.	
care facility. I will a surrogate, so they n	notify and send a c nay know who my	opy of this docum surrogate is.	nent to the following	eatment or admission to a heang persons other than my	lth
Name					
Signed					
Date					
Witnesses	1			<u></u>	
	2				

At least one witness must not be a husband or wife or a blood relative of the principal.